Public Health and the Law

The Emerging Relevance of Antitrust Laws to the Delivery of Health Care

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Abstract: Until relatively recently, antitrust enforcement in the delivery of health care was virtually non-existent.[1] Not even 15 years ago, many legal observers might have concluded that the professional services of medical care providers were exempted from the federal antitrust laws altogether; or that many providers were engaged in local activities beyond the reach of federal interstate commerce jurisdiction. Even 10 years ago, many providers were arguing that collective agreements among potential competitors were not only sound public policy, but also that such concerted activities were actively encouraged by various federal laws. Today, however, the enforcement of the federal antitrust is an integral part of the complicated legal environment of American health care delivery. (*Am J Public Health* 1985; 75:407–411.)

Statutory Background

Most public health professionals are unfamiliar even with the federal legislation itself. The original Sherman legislation in the late 1800s, and the various amendments and modifications to it in the ensuing century,[2] essentially:

- prohibit the exercise of monopoly power or any concerted attempt to restrain trade;
- attempt to specify certain practices that will be regarded as restraints on trade (e.g., interlocking directorates, product tying arrangements); and
- provide for judicial enforcement of these prohibitions, either by government agencies or by private parties.[3]

Most antitrust litigation involves allegations deriving from one of the two basic substantive provisions originally established by the Sherman Antitrust Act.

Section 1 of the Sherman Act prohibits concerted (i.e., two or more competitors) activities in restraint of trade:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or within foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony . . .

Section 2 prohibits *any* attempt to exercise monopoly power:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony . . .[4]

Jurisdictional and Statutory Exemptions

The initial round of litigation that signaled the emerging relevance of these prohibitions to the delivery of health care began with a series of decisions in the 1970s. The US Supreme Court rejected the so-called "learned profession" exemption[5] and firmly demonstrated its willingness to submit both the service delivery and the intraprofessional activities of physicians and other professionals to antitrust scrutiny.* The Court also rejected the argument that health care services are local activities[6]; the Court held that virtually no institutional or individual providers are shielded from antitrust liability by the "local activity" exemption.[7]**

The Supreme Court has also severely restricted the possible exclusion from antitrust scrutiny of many health financing activities under the "business of insurance" exemption created under the McCarran-Ferguson legislation.[8]*** In 1978[9] and again in 1983,[10] the Court affirmed that the exemption applies to only those activities that: 1) involve direct agreements between policyholders and the insurors; and 2) involve the underwriting of risks. As the Court has phrased it, McCarran Ferguson exempted from the antitrust laws only the "business of insurance," not the "business of insurors." Thus agreements between providers and health plans or health insurors, even those that ostensibly limit provider reimbursement or that are widely used in service

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*The "learned profession" exemption derives principally from a reading of §§ 1 and 2 of the Sherman Act limiting the federal antitrust laws to activities that involve "trade or commerce." Traditionally, antitrust experts had argued that the service delivery and intraprofessional activities of the "learned professions," e.g., lawyers, doctors, engineers, and other high prestige, self-regulated professionals, should be distinguished from other economic activities. While the exemption has been severely limited, the Court has left open the possibility that at least some of the intraprofessional activities of such groups with regard to ethical or quality standards may still be viewed differently for purposes of antitrust analysis. [*See* 421 U.S. 773, 788–89; 435 U.S. 679, 695.]

**The "local activity" exemption also derives from a reading of the language of the antitrust legislation, limiting the antitrust laws to activities that involve commerce or trade between states or with foreign nations. The recent pronouncements of the Supreme Court in *Rex* and other cases: 1) assume that Congress intended by this language to allow the scope of the antitrust laws to be as broad as the constitutional authority of Congress; and 2) require only a showing of a "substantial effect" on interstate commerce and not necessarily one that is either direct or intended.

***In 1945 Congress enacted the McCarran Ferguson Act expressly exempting the "business of insurance" from federal antitrust legislation to the extent that it was regulated by state law and did not involve "acts of boycott, coercion, or intimidation." Apparently, Congress was concerned that the antitrust laws should not interfere with the efforts of state insurance regulatory programs; and there was also concern that the determination of underwriting risks might require some amount of cooperation among competing insurance companies (e.g., sharing of data).

benefit and insurance schemes throughout the country, are potentially subject to antitrust scrutiny.

The Court has been even more restrictive in its definition of the "implied immunity" or "implied repeal" doctrine.† In a case followed closely by health planners throughout the country, the Court ruled in 1981 that a Blue Cross plan that refused to contract with a hospital, relying heavily on the recommendations of the local health systems agency (HSA) that the hospital had built "unnecessary beds," was not protected from antitrust liability by either the fact that the agency received federal funding or that the federal government was encouraging the development of health planning programs.[11] The Court held that only those activities specifically required by the federal law or necessary to carry out the objectives of the federal legislation, are exempt by the "implied immunity" doctrine. Applying this judicial posture to the federal health planning legislation (including the "pro-competition" amendments of 1979), the Court noted that at the time of the alleged violations, nothing in the legislation either compelled or approved of the actions taken by Blue Cross. The Court also noted that even if the HSA had specifically requested that Blue Cross adopt such a policy, *at the time* it would merely have been the recommendation of a private agency, that received government funding. The local HSA was not carrying out a federally mandated responsibility or regulatory authority under state law.

Following the Court's lead in the cases above, other courts have also severely narrowed the exemptions provided for activities taken under the encouragement of "state action"[12]†† and the *"Noerr-Pennington"*††† doctrine exempting actions involving governmental petitioning.[13]

The overall message of these cases is that modern courts view the federal antitrust legislation as establishing a fundamental national economic policy, and are willing to act as jealous guardians of this policy unless Congress clearly indicates otherwise. The Supreme Court has insisted that it must read the jurisdictional language of the antitrust legislation as broadly as possible, and must severely narrow the applicability of any exemption or limitation imposed on that jurisdiction. This message comes as no surprise to antitrust experts; it has been adopted in the interpretation of the federal antitrust legislation for some time. The message may, however, be somewhat surprising for health care providers, financiers, and planners who had frequently been advised that the character of their activities, the significant involvement in health care delivery of state and federal government, and the "special status" of health care made the prospects unlikely that they would be held answerable to charges that they engaged in unreasonable restraints of trade, the exercise of monopoly power, or the other acts prohibited by federal antitrust laws.

Having opened the door to the antitrust scrutiny of health care financing, various arrangements among providers and insurors, efforts taken ostensibly in compliance with health planning, and virtually all activities involving the delivery of services, the courts are now beginning to address the merits of these issues: the practically and theoretically difficult problem of applying substantive antitrust principles to the various practices and arrangements that constitute what the antitrust laws characterize as the "market(s)" for health care delivery.[14] This is the second round of application of antitrust law to health care delivery and its implications are just now unfolding.

Interpretation as Applied to Health Care Delivery

The gist of substantive antitrust analysis in most cases involves the identification of unreasonable restraints on trade or competition. Thus the basic inquiry is to apply the so-called "rule of reason": the courts must analyze: 1) the market(s) involved, i.e., who is selling what to whom; and 2) the acts or practices involved to determine whether competition is unreasonably affected. The difficulty of such an analysis is obvious. It requires the marshaling and interpretation of a tremendous amount of information, often in the face of disputed claims and allegations; and it requires the weighing of the pro-competitive and the anti-competitive effects of the contested acts or practices in order to identify the net impact on competition in the market(s). In doing so, the court must identify both actual market conditions and those that would exist without market restraints or imperfections. This judicial inquiry necessarily requires the application of a considerable dose of economic theory to the circumstances of modern health care delivery, an analysis that some critics argue is inappropriate and all agree requires some complicated adjustment in the traditional economic modeling of commercial behavior.

An important judicial doctrine that may be applied to make this economic analysis more manageable involves the application of the "per se" rule. As a court proceeds with its economic investigation of an industry and of the practices or activities alleged to violate antitrust laws, if the court identifies a practice that has been traditionally and frequently shown to be unreasonable in other industries, it may proceed no further than the identification of that practice.

†One of the inherent difficulties in interpreting the scope and application of the antitrust laws is the reconciliation of the essentially pro-competitive dictates of the federal antitrust laws with the requirements and prohibitions of various federal regulatory schemes, many of which promote or require cooperative arrangements and other non-competitive behavior among individuals or institutions otherwise subject to the antitrust laws. Where the courts are unable to separately reconcile antitrust and other congressional mandates, the courts treat any regulatory or other scheme enacted subsequent to the antitrust laws as effectively repealing the application of the antitrust laws to the extent necessary to carry out the new legislation. Since a variety of health planning and regulatory efforts have been attempted by Congress in the last several decades, many of which encourage and some of which require non-competitive activities, many experts have previously assumed that the "implied repeal" doctrine would provide antitrust exemption for a wide range of cooperative and joint efforts in developing resources, and in the financing and delivery of health care services.

††Beginning with the Supreme Court decision in *Parker v. Brown*, 317 U.S. 341 (1943), the courts have consistently read the federal antitrust legislation to imply an exemption for state government activities, and also activities sanctioned by state government—an exemption closely paralleling the logic of the "implied immunity" doctrine. As the *Parker v. Brown* exemption has generally been interpreted, private action is exempted as state action only where: 1) the statutory sanction for the activity is clearly articulated and affirmatively expressed as state policy; and 2) the private activity is actively supervised by the state itself. Thus some efforts to cooperate with state and local health planning agencies, and most efforts taken under their direction should be exempted; nevertheless, the breadth of this exemption should be read in light of the apparent reluctance of the Supreme Court and other modern courts to allow broad exemptions from antitrust enforcement.

†††The seminal decision for the so-called *"Noerr-Pennington"* doctrine, *Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961), ruled that any efforts taken to urge legislative action, even clearly anti-competitive activities, were exempt from the antitrust legislation. Later decisions ruled that the exemption applied as well to efforts urging executive or administrative action by the government, as well as participation in judicial proceedings. In later decisions it was argued that the exemption was both a proper reading of the intent of the antitrust laws and that the exemption of such activities was compelled by the First Amendment. Thus governmental "petitioning" of any type, despite its purpose or intent, is exempt; exceptions have only been allowed where the petitioning is shown to be a "sham"—a dilatory practice or a subterfuge for a direct attempt to inhibit competition or to inhibit the petitioning activities of a competitor.

The court will forego the weighing of the anti-competitive and pro-competitive effects of the practice under the particular circumstances. The practice or activity is considered unreasonable "per se." Whether and under what circumstances courts will apply a "per se" rule in analyzing various health care markets are therefore important questions to monitor as future decisions are handed down.

It should also be born in mind that, in the judicial application of economic analysis, the reasonableness of a restraint on trade is judged entirely by the impact on competition: the federal legislation allows only pro-competitive justifications for restraints on trade. Other social objectives of anti-competitive behavior, e.g., the improvement of the quality of the services rendered, are generally considered irrelevant for purposes of antitrust analysis.

The application of even these most basic antitrust principles to various aspects of health care delivery will be a source of considerable controversy and uncertainty in the coming years. The courts must define and analyze health services, financing, and resource allocation activities in terms of relevant markets and in terms that reflect both the actual and theoretical impact of competition. And they must do so in a legal environment at least partially skewed by such factors as the peculiarities of health care financing mechanisms and the historical pattern of governmental involvement in virtually all these activities.

The most significant test to date of the current Supreme Court's attitude was *Arizona v. Maricopa County Medical Society*.[15] In that case, medical care foundations maintained by local physicians were setting maximum fee schedules which participating physicians agreed to accept in full for services to patients enrolled in health plans approved by the foundations. Each foundation also performed peer review and fiscal functions for the insurance plans. The Arizona Attorney General brought an antitrust action claiming that the local medical societies, individual physicians, and the foundations were essentially fixing prices in violation of the federal antitrust laws. The defendants argued that their actions did not constitute classic price fixing and that, given the cost savings by consumers due to the maximum limits established by the arrangements and the other advantages for the health plans, such agreements should be viewed as reasonable.

The Supreme Court held that the arrangements were the kind of concerted restraint on competition illegal "per se" under the antitrust laws, and the price fixing arrangement was struck down without any further economic analysis of its actual impact.

The Court's reasoning provides an excellent illustration of both per se analysis and the rigor with which the Court believes competition is protected by the antitrust laws. In essence, the Court held that Congress has not given the courts the discretion to consider whether under most circumstances anti-competitive activity can be fair or good public policy. The only substantive issue, unless the activity is exempted, is whether the arrangement has such a negative impact on competition so as to constitute an unreasonable restraint on trade. And where the act or practice is one of several practices traditionally regarded as illegal "per se" in other markets, that analysis is abbreviated and the negative impact on competition is assumed. Once the Court concluded that the arrangement constituted price fixing, the Court even indicated that if the effect of the price fixing involved in the case had been in fact to lower prices, the cost of eliminating competition would be presumed to outweigh any advantages of the lower prices.

In its most recent antitrust decision involving health care, the Court affirmed its commitment to a rigorous enforcement of the antitrust laws, but had trouble defining the specific principles to apply and the relevant markets involved. *Jefferson Parish Hospital v. Hyde*[16] involved an exclusive contract between a private hospital and an anesthesiology group (Roux) under which the hospital agreed that any patient receiving surgery would use one of the group's physicians. As a consequence of this agreement, when another anesthesiologist applied for hospital privileges, he was denied. The physician sued in federal court claiming that this constituted a tying agreement, one of the specific restraints on trade prohibited under the federal antitrust statutes.

Under antitrust analysis, a tying arrangement is a form of marketing where a seller insists on selling two products or services together. One product, the "tying product" is only sold if the buyer agrees also to purchase another, the "tied product." In their strictest form, tying arrangements are considered an unreasonable restraint on trade and illegal per se. The courts, however, have been somewhat reluctant to treat all tying arrangements as illegal "per se". Only where the buyer is actually forced to accept the second product is the package sale regarded as an illegal "tying." Basically, the seller has to be shown to have sufficient market power to force the buyer to accept a "tied product" that the buyer did not want at all or would have preferred to buy elsewhere on different terms. Presumably, only such tying arrangements force the buyer to do something that would not be done in a competitive market and only such a forcing would either exclude existing competitors or discourage new ones, traditional measures of anti-competitive impact. Thus, in order to hold a tying arrangement illegal "per se", the court must not only identify a tying arrangement but the kind of tying arrangement prohibited under the antitrust laws. As a result, the distinction between the threshold analysis for application of a "per se" rule and the full analysis under a rule of reason becomes somewhat blurred in tying cases.

In *Jefferson*,[16] Justice Stevens, speaking for an extremely divided Court (four justices concurred with the decision, but dissented from the reasoning), conceded that there were two separate products that were apparently tied together by the seller. The hospital had argued that they were integrated services and that they should be treated as one product. But the majority found that there was no forcing of their purchase. Looking to the market power of the hospital, the Court held that the circumstances of hospital care in the particular market area had not been shown to allow this hospital to exercise sufficient forcing of a tied purchase. Patients in the service area of the hospital had a number of alternatives. Indeed, evidence indicated that a majority of the patients in the market area went to other hospitals; thus, patients wanting to purchase the tied product elsewhere or on other terms were able to do so and the tying arrangement did not inhibit their ability to exercise these options.

Having rejected the application of the "per se" rule, the Court went on to apply the "rule of reason" to the tying arrangements, i.e., to evaluate the actual competitive effects of the exclusive contract. In a surprisingly brief analysis, Justice Stevens rejected the allegation that the agreement represented an unreasonable restraint on trade:

> In sum, all that the record establishes is that the choice of anesthesiologists at East Jefferson has been limited to one of the four doctors who are associated with Roux and therefore

> have staff privileges. Even if Roux did not have an exclusive contract, the range of alternatives open to the patient would be severely limited by the nature of the transaction and the hospital's unquestioned right to exercise some control over the identity and the number of doctors to whom it accords staff privileges. If respondent is admitted to the staff of East Jefferson, the range of choice will be enlarged from four to five doctors, but the most significant restraints on the patient's freedom to select a specific anesthesiologist will nevertheless remain. Without a showing of actual adverse effect on competition, respondent cannot make out a case under the antitrust laws, and no such showing has been made.[17]

Jefferson may be a good illustration of the rule of reason analysis. Obviously the contract between the hospital and the anesthesiology group restrained trade and affected competition. Patients could only buy the services of the hospital if they accepted the group's physician services. But such an arrangement did not have an unreasonable effect on competition: the Court found no showing that this contract put any restraint on a market that would not be expected under normal market conditions. Patients could still buy the services of the plaintiff or any other anesthesiologist at other hospitals. Thus, according to the Court, competitive conditions still existed in the market despite the exclusive contract. Conversely, however, had there been no other hospital available in the service area, or even fewer hospitals, the net impact on competition might have been analyzed differently and the Court may have found a either forcing inherent in the mandatory tying of the two products or a resulting net impact on competition sufficient to violate the prohibitions inherent in the antitrust laws.

Conclusions

This column has offered an introduction to the federal antitrust legislation and to recent judicial decisions that have indicated the court's enthusiastic intent to apply antitrust principles to various aspects of health care delivery.

For public health professionals, who may have been schooled to believe that health care delivery is through "systems" and not "markets" and that health care cannot or should not be modeled by reference to traditional economic concepts, the recent judicial attempts to assess the impact on competition of various financing arrangements, provider activities, and even government encouraged planning efforts may appear a rather strained fit of economic theory to actual practice. But however strained those efforts may in fact be, the courts, led by the Supreme Court, have clearly staked out the modern judicial posture: there is nothing inherent in the nature of health care services or in the manner in which they are provided or financed which significantly alters the judicial function mandated under the federal antitrust legislation. In the view of the courts, Congress has established a fundamental economic policy favoring competition. It has empowered governmental agencies to carry out that policy, and allowed private parties claiming harm from antitrust violations to seek private judicial remedies, including individual liability for damages. Nothing that the courts have encountered thus far has persuaded them that this policy should be applied any differently with respect to health care delivery than to other economic activities.

How and under what circumstances this national policy will be enforced as the Federal Trade Commission, state and federal attorney generals, and private litigants assail insuring schemes, planning programs, preferred provider agreements, and the like, is very difficult to predict even for antitrust experts let alone for public health professionals whose introduction to antitrust law may well be rather recent, or who may be predisposed to reject in whole or in part the underlying assumptions of the antitrust laws. Indeed, until those in public health can overcome this predisposition to the basis for antitrust enforcement, neither individual cases nor their implications may be adequately understood or reacted to.

But part of the difficulty is inherent in these cases. The antitrust laws, unlike virtually any other area of the law, require that the courts in their interpretative function not only give specific meaning and application to general legal principles, but require as well that the courts divine that meaning by application of the economic theory that is essentially incorporated by reference into the federal legislation. The result is a judicial function that is unique and inherently complicated, and particularly so when those antitrust principles are applied to a new set of circumstances and to an activity that fits into the mold of traditional market analysis only with considerable shaping and qualification. Moreover, as these cases demonstrate, the judicial function relies heavily on the analysis of the specific arrangements, the factual setting, and the prevailing market conditions at the time of the alleged violation. Extending the decisions enunciated in each case, particularly for purposes of anticipating future decisions, is necessarily speculative—even when applied to industries or commercial activities with which there has been some antitrust history, let alone to an activity that has only recently come under antitrust scrutiny.

From a pragmatic point of view, it would probably be best to view these initial cases as preliminary signals of judicial intent, rather than predictive roadmaps of future applications of antitrust principles to various aspects of health care delivery. That is to say, the judicial interpretation of various "markets" and the impact on competition in those markets is likely to evolve as antitrust principles are applied to other circumstances and as the implications of these cases are further refined. Or to put it somewhat differently, while public health professionals would be well advised to follow these and future cases closely and to seek legal counsel as questions of their interpretation arise, the counsel they receive will, or at least should be, cautious and speculative.

REFERENCES

1. *See, e.g., American Medical Assoc. v. U.S.*, 317 U.S. 519 (1943); *U.S. v. Oregon Medical Assoc.*, 434 U.S. 326 (1952).
2. *See* E Gellhorn, *Antitrust Law and Economics*, 2d ed, 1981; L Sullivan, *Antitrust*, 1977.
3. 15 U.S.C. §§ 1–40 (1983).
4. 15 U.S.C. §§ 1 & 2 (1983).
5. *See Goldfarb v. Virginia State Bar*, 421 U.S. 733 (1976); *National Society of Professional Engineers v. U.S.*, 435 U.S. 679 (1978).
6. *Hospital Building Co. v. Rex Hospital Trustees*, 425 U.S. 738 (1976).
7. *See* Wing and Silton: *Constitutional Authority for Extending Federal Control Over the Delivery of Health Care*. 57 *N.C.L. Rev.* 1423, 1460–73, 1979.
8. *See* 15 U.S.C. §§ 1011 *et seq.* (1976).
9. *Group Life & Health Insurance co. v. Royal Drug Co.*, 440 U.S. 205 (1978).
10. *Union Labor Life Co. v. Pireno*, 458 U.S. 119 (1983).
11. *National Gerimedical Hospital and Geronotology Center v. Blue Cross of Kansas City and Blue Cross Assoc.*, 452 U.S. 378 (1981); *See also Hospital Building Co. v. Trustees of Rex Hospital*, 691 F.2d 678 (6th Cir. 1982).
12. For one illustration of the "state action" or *"Parker v. Brown"* exemp-

tion, see *Feminist Women's Health Center v. Mohammed*, 586 F.2d 53D (1978), *cert. den.*, 444 U.S. 924 (1979).
13. *See*, e.g., *Virginia Academy of Clinical Psychologists v. Blue Shield*, 624 F.2d 476 (1980), *cert. denied* 450 U.S. 916 (1981).
14. *See* Havighurst: *Competition in Health Services: Overview Issues and Answers*. 34 *Vand. L. Rev.* 1117, 1982.
15. 457 U.S. 332 (1982).
16. *Jefferson Parish Hospital District No. 2 v. Hyde*, 104 S. Ct. 1551 (1984).
17. *Id.* at 1568.

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